

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0032979</u></p> <p>Facility Name: <u>Hitz Memorial Home</u></p> <p>Address: <u>201 Belle Street</u> <u>Alhambra</u> <u>62001</u> Number City Zip Code</p> <p>County: <u>Madison</u></p> <p>Telephone Number: <u>(618) 488-2355</u> Fax # <u>(618) 488-2361</u></p> <p>IDPA ID Number: <u>371222548001</u></p> <p>Date of Initial License for Current Owners: <u>01/01/1968</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501c(3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Scheffel & Company, P.C.</u> Telephone Number: <u>(618) 656-1206</u></p>	<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501c(3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2001</u> to <u>06/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1144 673 1281 828">Officer or Administrator of Provider</td> <td data-bbox="1281 673 1921 747">(Signed) _____ (Date) _____ (Type or Print Name) <u>Marcia Haslett</u></td> </tr> <tr> <td data-bbox="1144 747 1281 828"></td> <td data-bbox="1281 747 1921 828">(Title) <u>Administrator</u></td> </tr> <tr> <td data-bbox="1144 828 1281 1039">Paid Preparer</td> <td data-bbox="1281 828 1921 1039">(Signed) _____ (Date) _____ (Print Name and Title) <u>Dennis E. Ulrich, Certified Public Accountant</u> (Firm Name & Address) <u>Scheffel & Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, IL 62025</u> (Telephone) <u>(618) 656-1206</u> Fax # <u>(618) 656-3536</u></td> </tr> </table> <p align="right">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____ (Type or Print Name) <u>Marcia Haslett</u>		(Title) <u>Administrator</u>	Paid Preparer	(Signed) _____ (Date) _____ (Print Name and Title) <u>Dennis E. Ulrich, Certified Public Accountant</u> (Firm Name & Address) <u>Scheffel & Company, P.C.</u> <u>143 North Kansas Street, Edwardsville, IL 62025</u> (Telephone) <u>(618) 656-1206</u> Fax # <u>(618) 656-3536</u>
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Facility Name & ID Number Hitz Memorial Home

0032979 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>34</u>	Skilled (SNF)	<u>34</u>	<u>12,410</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>33</u>	Intermediate (ICF)	<u>33</u>	<u>12,045</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>67</u>	TOTALS	<u>67</u>	<u>24,455</u>	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment			5 Total	
		3 Public Aid Recipient	4 Private Pay	Other		
8	SNF	<u>1,205</u>		<u>1,157</u>	<u>2,362</u>	8
9	SNF/PED					9
10	ICF	<u>11,251</u>	<u>8,596</u>		<u>19,847</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>12,456</u>	<u>8,596</u>	<u>1,157</u>	<u>22,209</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.82%

D. How many bed-hold days during this year were paid by Public Aid? 61 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)

Assisted Living

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES NO

I. On what date did you start providing long term care at this location?
Date started 01/01/1968

J. Was the facility purchased or leased after January 1, 1978?
YES Date _____ NO

K. Was the facility certified for Medicare during the reporting year?
YES NO If YES, enter number of beds certified 9 and days of care provided 1,157

Medicare Intermediary Mutual Of Omaha

IV. ACCOUNTING BASIS

ACCRUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number

Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	129,085	7,437	4,484	141,006		141,006	(542)	140,464		1
2	Food Purchase		86,621		86,621		86,621		86,621		2
3	Housekeeping	51,030	3,286		54,316		54,316		54,316		3
4	Laundry	68,843	8,239	1,671	78,753		78,753		78,753		4
5	Heat and Other Utilities			72,250	72,250		72,250	(2,976)	69,274		5
6	Maintenance	59,575	3,473	31,312	94,360		94,360		94,360		6
7	Other (specify):*										7
8	TOTAL General Services	308,533	109,056	109,717	527,306		527,306	(3,518)	523,788		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,005,949	67,931	3,697	1,077,577		1,077,577	(9,051)	1,068,526		10
10a	Therapy		2,776	169,049	171,825		171,825		171,825		10a
11	Activities	57,532		372	57,904		57,904		57,904		11
12	Social Services	30,867	56	1,872	32,795		32,795		32,795		12
13	Nurse Aide Training			1,800	1,800		1,800		1,800		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,094,348	70,763	181,590	1,346,701		1,346,701	(9,051)	1,337,650		16
	C. General Administration										
17	Administrative	58,665			58,665		58,665		58,665		17
18	Directors Fees										18
19	Professional Services			14,505	14,505		14,505		14,505		19
20	Dues, Fees, Subscriptions & Promotions			17,351	17,351		17,351	(7,466)	9,885		20
21	Clerical & General Office Expenses	79,161	5,855	27,035	112,051		112,051	(3,941)	108,110		21
22	Employee Benefits & Payroll Taxes			232,691	232,691		232,691		232,691		22
23	Inservice Training & Education			1,775	1,775		1,775		1,775		23
24	Travel and Seminar			4,328	4,328		4,328	(66)	4,262		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			44,963	44,963		44,963		44,963		26
27	Other (specify):*										27
28	TOTAL General Administration	137,826	5,855	342,648	486,329		486,329	(11,473)	474,856		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,540,707	185,674	633,955	2,360,336		2,360,336	(24,042)	2,336,294		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number

Hitz Memorial Home

#0032979

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			186,746	186,746		186,746	(123,999)	62,747			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			135,062	135,062		135,062	(94,609)	40,453			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership			321,808	321,808		321,808	(218,608)	103,200			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		25,952		25,952		25,952		25,952			39
40	Barber and Beauty Shops			14,776	14,776		14,776		14,776			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,683	36,683		36,683		36,683			42
43	Other (specify):*	120,777	20,395	107,189	248,361		248,361	(248,361)				43
44	TOTAL Special Cost Centers	120,777	46,347	158,648	325,772		325,772	(248,361)	77,411			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,661,484	232,021	1,114,411	3,007,916		3,007,916	(491,011)	2,516,905			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(542)	1		4
5	Telephone, TV & Radio in Resident Rooms	(2,976)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(10,652)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(66)	24		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(3,941)	21		24
25	Fund Raising, Advertising and Promotional	(6,757)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(709)	20		28
29	Other-Attach Schedule See Attached Schedule	(465,368)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (491,011)		\$	30

OHF USE ONLY					
48		49	50	51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (491,011)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Hitz Memorial Home

ID# 0032979
 Report Period Beginning: 07/01/2001
 Ending: 06/30/2002

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Assisted Living Salary Expenses:	\$		1
2	Activities	(1,493)	43	2
3	Dietary	(32,920)	43	3
4	House Daughters	(44,367)	43	4
5	Social Services	(19,324)	43	5
6	Supervisor	(22,673)	43	6
7				7
8	Assisted Living Supplies Expenses:			8
9	Food and Supplies	(17,832)	43	9
10	General	(370)	43	10
11	Laundry Supplies	(343)	43	11
12	Maintenance Supplies	(1,126)	43	12
13	Housekeeping Supplies	(724)	43	13
14				14
15	Assisted Living Other Expenses:			15
16	Telephone and Cable TV	(1,475)	43	16
17	Employee Benefits and Payroll Taxes	(29,499)	43	17
18	Insurance	(29,463)	43	18
19	Professional Fees	(4,905)	43	19
20	Administrative	(9,258)	43	20
21				21
22	Assisted Living and Rental Other Expenses:			22
23	Repairs and Maintenance	(6,304)	43	23
24	Utilities	(23,480)	43	24
25	Security Services	(2,805)	43	25
26				26
27				27
28	Assisted Living Mortgage Interest	(83,957)	32	28
29	Non-Care Asset Depreciation	(123,999)	30	29
30	Resident Personal Purchases	(9,051)	10	30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(465,368)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(542)	0	0	0	0	0	0	0	0	0	0	(542)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,976)	0	0	0	0	0	0	0	0	0	0	(2,976)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(3,518)	0	0	0	0	0	0	0	0	0	0	(3,518)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(9,051)	0	0	0	0	0	0	0	0	0	0	(9,051)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(9,051)	0	0	0	0	0	0	0	0	0	0	(9,051)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(7,466)	0	0	0	0	0	0	0	0	0	0	(7,466)	20
21	Clerical & General Office Expenses	(3,941)	0	0	0	0	0	0	0	0	0	0	(3,941)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(66)	0	0	0	0	0	0	0	0	0	0	(66)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	(11,473)	0	0	0	0	0	0	0	0	0	0	(11,473)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,042)	0	0	0	0	0	0	0	0	0	0	(24,042)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Hit Memorial Home# 0032979

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(123,999)	0	0	0	0	0	0	0	0	0	0	(123,999) 30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0 31
32	Interest	(94,609)	0	0	0	0	0	0	0	0	0	0	(94,609) 32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0 33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0 34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0 35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 36
37	TOTAL Ownership	(218,608)	0	0	0	0	0	0	0	0	0	0	(218,608) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	(248,361)	0	0	0	0	0	0	0	0	0	0	(248,361) 43
44	TOTAL Special Cost Centers	(248,361)	0	0	0	0	0	0	0	0	0	0	(248,361) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(491,011)	0	0	0	0	0	0	0	0	0	0	(491,011) 45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Illinois South conference of the United Church of Christ	100%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger		5 Cost to Related Organization		6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization					
1	V		\$				\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total		\$				\$	\$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference
						Hours	Percent	Description	Amount	
1	N/A								\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13								TOTAL	\$	13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2001 Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization _____
 Street Address _____
 City / State / Zip Code _____
 Phone Number () _____
 Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number Hitz Memorial Home # 0032979 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
		A. Directly Facility Related										
Long-Term												
1							\$	\$			\$	1
2	Bank of Edwardsville											2
3	1999 Bond Issue		X	Nursing Facility Mortgage, 36.93%		03/01/99	1,006,182	805,876	03/01/14		49,160	3
4	1999 Bond Issue Cost		X	Issue Cost Amortization		03/01/99	29,198	22,713			1,945	4
5												5
Working Capital												
6												6
7												7
8												8
9	TOTAL Facility Related						\$ 1,035,380	\$ 828,589			\$ 51,105	9
B. Non-Facility Related*												
10												10
11	Bank Of Edwardsville											11
12	1999 Bond Issue		X	Assisted Living Mortgage, 63.07%		03/01/99	1,718,571	1,376,296	03/01/14		83,957	12
13												13
14	TOTAL Non-Facility Related						\$ 1,718,571	\$ 1,376,296			\$ 83,957	14
15	TOTALS (line 9+line14)						\$ 2,753,951	\$ 2,204,885			\$ 135,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 135,062 Line # 32

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number **Hitz Memorial Home**# **0032979** Report Period Beginning: **07/01/2001** Ending: **06/30/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1.	Real Estate Tax accrual used on 2001 report.	\$	N/A		1
2.	Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$			2
3.	Under or (over) accrual (line 2 minus line 1).	\$			3
4.	Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	\$			4
5.	Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$			5
6.	Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$			6
7.	Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$			7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1997	_____	8	
		1998	_____	9	
		1999	_____	10	
		2000	_____	11	
		2001	_____	12	
FOR OHF USE ONLY					
13	FROM R. E. TAX STATEMENT FOR 2001	\$			13
14	PLUS APPEAL COST FROM LINE 5	\$			14
15	LESS REFUND FROM LINE 6	\$			15
16	AMOUNT TO USE FOR RATE CALCULATION	\$			16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Hitz Memorial Home COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0032979

CONTACT PERSON REGARDING THIS REPORT Marcia Haslett

TELEPHONE (618) 488-2355 FAX #: (618) 488-2361

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D)
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1. <u> </u>	<u>Not-For-Profit organization, exempt</u>	\$ <u> </u>	\$ <u> </u>
2. <u> </u>	<u>from real estate taxes</u>	\$ <u> </u>	\$ <u> </u>
3. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
4. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u> </u>	\$ <u> </u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Hitz Memorial Home# 0032979 Report Period Beginning:07/01/2001 Ending:06/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,077 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Assisted Living Facility, 12944 sq. ft., 26 unitsChild Care Center (Rental Space), 5,726 sq. ft.F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>		<u>1976</u>	<u>\$ 45,384</u>	<u>1</u>
2					<u>2</u>
3	TOTALS			\$ 45,384	3

Facility Name & ID Number Hitz Memorial Home# 0032979

Report Period Beginning:

07/01/2001 Ending: 06/30/2002**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9		
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	33		1970	\$ 176,881	\$ 4,422	40	\$ 4,422	\$	\$ 140,768	4
5	34		1975	418,286	10,457	40	10,457		281,472	5
6										6
7										7
8										8
Improvement Type**										
9	Improvements		1971	19,945	499	40	499		15,499	9
10	Improvements		1972	90		10			90	10
11	Improvements		1974	23,177	579	40	579		16,079	11
12	Improvements		1976	81,417	2,035	40	2,035		53,091	12
13	Improvements		1977	6,650	166	40	166		4,226	13
14	Improvements		1979	3,000	75	40	75		1,731	14
15	Improvements and Garage		1980	15,638	391	40	391		8,633	15
16	Improvements		1982	2,416	60	40	60		1,213	16
17	Roof and Improvements		1983	138,325	3,458	40	3,458		65,993	17
18	Roof and Improvements		1984	143,005	3,575	40	3,575		64,948	18
19	Dining Room		1985	28,447	711	40	711		12,327	19
20	Architecture Fees/Roof Repair		1987	12,112	303	40	303		4,567	20
21	Architecture Fees/Improvements		1988	8,001	200	40	200		2,817	21
22	Solarium and Architecture Fees		1989	67,025	1,676	40	1,676		21,923	22
23	Remodeling & New Garage		1990	29,672	916	40	916		10,994	23
24	Remodeling/Funrace/Control Temps/Architect Fees		1993	36,433	2,151	40	2,151		28,336	24
25	Sprinkler System/ Water Heaters		1994	11,606	802	40	802		6,406	25
26	Roof Repair		1997	22,000	550	40	550		2,750	26
27	Air Conditioner		1998	5,439	136	40	136		555	27
28	Tank Replacement		1998	14,313	716	20	716		2,326	28
29	Air Conditioner		1999	3,280	164	20	164		519	29
30	Door Alarm		2000	1,164	116	10	116		320	30
31	Door Alarm		2000	1,563	156	10	156		300	31
32	Water Heater		2000	4,044	270	15	270		494	32
33	Kitchen Sewer Line		2000	2,721	181	15	181		317	33
34										34
35										35
36										36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37			\$	\$		\$	\$	\$		37
38										38
39										39
40										40
41										41
42										42
43										43
44										44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 1,276,650	\$ 34,765		\$ 34,765	\$	\$ 748,694		70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 446,845	\$ 20,912	\$ 20,912	\$	10	\$ 371,592	71
72	Current Year Purchases	6,730	698	698		10	698	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 453,575	\$ 21,610	\$ 21,610	\$		\$ 372,290	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	Van Lift for 2000 Dodge	2000	\$ 5,687	\$ 5,235	\$ 5,235	\$	5	\$ 11,342	76
77	Resident Transportation	Dodge Ram Wagon, 2000	2000	26,173	1,137	1,137		5	2,275	77
78										78
79										79
80	TOTALS			\$ 31,860	\$ 6,372	\$ 6,372	\$		\$ 13,617	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,807,469	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,747	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 62,747	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,134,601	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	A.L. & C.C. Bldg. & Improvements	\$ 3,921,258	\$ 98,430	\$ 913,247	86
87	A.L. & C.C. Equipment	317,010	25,569	275,176	87
88					88
89	Vehicles	45,123		45,123	89
90	Land-Asst. Living & Child Care	25,000			90
91	TOTALS	\$ 4,308,391	\$ 123,999	\$ 1,233,546	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: None

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____
13. /2004 \$ _____
14. /2005 \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

YES NO

16. Rental Amount for movable equipment: \$ 0 Description: _____

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input checked="" type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input checked="" type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			
		1	2	3	4
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,500	\$	\$ 1,500
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		\$ 300		\$ 300
9	TOTALS	\$	\$ 1,800	\$	\$ 1,800
10	SUM OF line 9, col. 1 and 2 (e)	\$	\$ 1,800		

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6 Supplies (Actual or Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Outside Practitioner (other than consultant)		Units	Cost						
					Units	Cost								
1	Licensed Occupational Therapist	10a-3	hrs	\$	N/A	\$ 74,226					\$	74,226	1	
2	Licensed Speech and Language Development Therapist	10a-3	hrs		N/A	29,635						29,635	2	
3	Licensed Recreational Therapist		hrs										3	
4	Licensed Physical Therapist	10a-3	hrs		N/A	65,188						65,188	4	
5	Physician Care		visits										5	
6	Dental Care		visits										6	
7	Work Related Program		hrs										7	
8	Habilitation		hrs										8	
9	Pharmacy	39-2	# of prescripts							25,952		25,952	9	
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs										10	
11	Academic Education		hrs										11	
12	Exceptional Care Program												12	
13	Other (specify):												13	
14	TOTAL			\$		\$ 169,049			\$	25,952		\$	195,001	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2001

Ending:

06/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

	1	2	
	Operating	After Consolidation*	
A. Current Assets			
1 Cash on Hand and in Banks	\$ 484,033	\$	1
2 Cash-Patient Deposits	1,950		2
3 Accounts & Short-Term Notes Receivable-Patients (less allowance (32,000))	301,058		3
4 Supply Inventory (priced at)	33,313		4
5 Short-Term Investments			5
6 Prepaid Insurance	121,275		6
7 Other Prepaid Expenses	3,610		7
8 Accounts Receivable (owners or related parties)			8
9 Other(specify):			9
10 TOTAL Current Assets (sum of lines 1 thru 9)	\$ 945,239	\$	10
B. Long-Term Assets			
11 Long-Term Notes Receivable			11
12 Long-Term Investments			12
13 Land	70,384		13
14 Buildings, at Historical Cost	595,167		14
15 Leasehold Improvements, at Historical Cost	4,602,741		15
16 Equipment, at Historical Cost	847,568		16
17 Accumulated Depreciation (book methods)	(2,368,147)		17
18 Deferred Charges			18
19 Organization & Pre-Operating Costs	29,198		19
20 Accumulated Amortization - Organization & Pre-Operating Costs	(6,484)		20
21 Restricted Funds			21
22 Other Long-Term Assets (specify):			22
23 Other(specify):			23
24 TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,770,427	\$	24
25 TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,715,666	\$	25

	1	2	
	Operating	After Consolidation*	
C. Current Liabilities			
26 Accounts Payable	\$ 200,583	\$	26
27 Officer's Accounts Payable			27
28 Accounts Payable-Patient Deposits	1,950		28
29 Short-Term Notes Payable			29
30 Accrued Salaries Payable	116,367		30
31 Accrued Taxes Payable (excluding real estate taxes)			31
32 Accrued Real Estate Taxes(Sch.IX-B)			32
33 Accrued Interest Payable			33
34 Deferred Compensation			34
35 Federal and State Income Taxes	1,594		35
Other Current Liabilities(specify):			
36 Bonds Payable	151,977		36
37			37
38 TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 472,471	\$	38
D. Long-Term Liabilities			
39 Long-Term Notes Payable			39
40 Mortgage Payable			40
41 Bonds Payable	2,030,195		41
42 Deferred Compensation			42
Other Long-Term Liabilities(specify):			
43			43
44			44
45 TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 2,030,195	\$	45
46 TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,502,666	\$	46
47 TOTAL EQUITY(page 18, line 24)	\$ 2,213,000	\$	47
48 TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,715,666	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 2,237,107	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 2,237,107	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(24,107)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (24,107)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 2,213,000	24 *

* This must agree with page 17, line 47.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 2,703,285	1
2	Discounts and Allowances for all Levels	(129,051)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,574,234	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	40,831	5
6	Therapy	198,888	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 239,719	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,433	13
14	Non-Patient Meals	542	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	8,704	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	11,421	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 35,100	23
D. Non-Operating Revenue			
24	Contributions	119,512	24
25	Interest and Other Investment Income***	10,652	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 130,164	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous	4,592	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 4,592	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,983,809	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	527,306	31
32	Health Care	1,346,701	32
33	General Administration	486,329	33
B. Capital Expense			
34	Ownership	321,808	34
C. Ancillary Expense			
35	Special Cost Centers	289,089	35
36	Provider Participation Fee	36,683	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,007,916	40
41	Income before Income Taxes (line 30 minus line 40)**	(24,107)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (24,107)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

**** Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Hitz Memorial Home

0032979

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,880	2,080	\$ 47,390	\$ 22.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	6,452	6,983	122,637	17.56	3
4	Licensed Practical Nurses	16,867	18,332	262,303	14.31	4
5	Nurse Aides & Orderlies	58,229	61,820	555,671	8.99	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,792	2,248	27,884	12.40	9
10	Activity Assistants	3,615	3,807	29,648	7.79	10
11	Social Service Workers	1,742	2,320	30,867	13.30	11
12	Dietician					12
13	Food Service Supervisor	1,704	2,080	25,171	12.10	13
14	Head Cook					14
15	Cook Helpers/Assistants	11,037	11,929	103,914	8.71	15
16	Dishwashers					16
17	Maintenance Workers	3,439	3,915	59,575	15.22	17
18	Housekeepers	5,266	5,752	51,030	8.87	18
19	Laundry	6,843	7,369	68,843	9.34	19
20	Administrator	1,888	2,080	58,665	28.20	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,956	5,911	79,161	13.39	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,815	2,057	17,948	8.73	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Assisted Living</u>	13,485	14,352	120,777	8.42	33
34	TOTAL (lines 1 - 33)	141,010	153,035	\$ 1,661,484 *	\$ 10.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	128	\$ 4,184	1-3	35
36	Medical Director	400/mo.	4,800	9-3	36
37	Medical Records Consultant	16	709	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	75/mo.	750	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	62	1,052	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	206	\$ 11,495		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
Marcia Haslett	Adminstrator	0.00%	\$ 58,665	Workers' Compensation Insurance	\$ 64,010	IDPH License Fee	\$ 5,559	
				Unemployment Compensation Insurance	4,825	Advertising: Employee Recruitment	5,559	
				FICA Taxes	113,862	Health Care Worker Background Check	1,174	
				Employee Health Insurance	31,064	(Indicate # of checks performed <u>98</u>)		
				Employee Meals		Dues & Subscriptions	3,152	
				Illinois Municipal Retirement Fund (IMRF)*		Promotional & Public Relations	6,757	
				Retirement Plan Contribution	13,910	Yellow Pages	709	
				Other Employee Benefits	5,020			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,665	TOTAL (agree to Schedule V, line 22, col.8)		TOTAL (agree to Sch. V, line 20, col. 8)		
B. Administrative - Other						Less: Public Relations Expense (6,757)		
Description			Amount			Non-allowable advertising ()		
			\$			Yellow page advertising (709)		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$					
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Scheffel & Company, P.C.	Accounting		\$ 13,264				Out-of-State Travel	\$
Schiff, Hardin & White	Legal		1,241				In-State Travel	
							Seminar Expense	4,328
							Non-Direct Patient Care Seminars	(66)
							Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 14,505	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)	\$ 4,262

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Hitz Memorial Home# 0032979Report Period Beginning: 07/01/2001Ending: 06/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. LSN \$3,611, CHHSM \$1,466, INHAA \$75, ALFA \$75
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 19,739 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 36,683
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? Yes For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? Yes Indicate the amount. \$ 542
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 100%
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
- g. Does the facility transport residents to and from day training? No**
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Scheffel & Company, P.C. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Not yet completed.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.